

<div>FORM HHCS-1 (3-29-96)</div> <div>U.S. DEPARTMENT OF COMMERCE BUREAU OF THE CENSUS ACTING AS COLLECTING AGENT FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES U.S. PUBLIC HEALTH SERVICE CENTERS FOR DISEASE CONTROL AND PREVENTION NATIONAL CENTER FOR HEALTH STATISTICS</div> <div>AGENCY QUESTIONNAIRE 1996 NATIONAL HOME AND HOSPICE CARE SURVEY</div>		<div>NOTICE – Public reporting burden for this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to DHHS Reports Clearance Officer; Paperwork Reduction Project (0920-0298) Room 531-H; Hubert H. Humphrey Bldg.; 200 Independence Ave., SW; Washington, DC 20201. Information contained on this form which would permit identification of any individual or establishment has been collected with a guarantee that it will be held in strict confidence, will be used for purposes stated for this study, and will not be disclosed or released to others without the consent of the individual or establishment in accordance with Section 308(d) of the Public Health Service Act (42 USC 242m).</div>																																								
<div>Section A – AGENCY INFORMATION</div> <div>1a. Agency telephone number</div> <div>b. Alternate telephone number</div> <div>c. Alternate telephone number</div> <div>2a. Administrator name</div> <div>b. Respondent name</div>		Notes																																								
<div>Section B – RECORD OF CONTACTS</div> <table><thead><tr><th>Day (a)</th><th>Date (b)</th><th>Time (c)</th><th>Notes (d)</th></tr></thead><tbody><tr><td></td><td></td><td>a.m. p.m.</td><td></td></tr><tr><td></td><td></td><td>a.m. p.m.</td><td></td></tr><tr><td></td><td></td><td>a.m. p.m.</td><td></td></tr><tr><td></td><td></td><td>a.m. p.m.</td><td></td></tr><tr><td></td><td></td><td>a.m. p.m.</td><td></td></tr><tr><td></td><td></td><td>a.m. p.m.</td><td></td></tr><tr><td></td><td></td><td>a.m. p.m.</td><td></td></tr><tr><td></td><td></td><td>a.m. p.m.</td><td></td></tr><tr><td></td><td></td><td>a.m. p.m.</td><td></td></tr></tbody></table>			Day (a)	Date (b)	Time (c)	Notes (d)			a.m. p.m.				a.m. p.m.				a.m. p.m.				a.m. p.m.				a.m. p.m.				a.m. p.m.				a.m. p.m.				a.m. p.m.				a.m. p.m.	
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<div>Section C – RECORD OF INTERVIEW</div> <div>1. STATUS OF INTERVIEW – Mark (X) appropriate box. 01 <input type="checkbox"/> Complete interview 02 <input type="checkbox"/> Partial interview 03 <input type="checkbox"/> Refusal 04 <input type="checkbox"/> Unable to locate 05 <input type="checkbox"/> Not a Hospice/Home Health Agency 06 <input type="checkbox"/> Temporarily closed 07 <input type="checkbox"/> Not yet in operation 08 <input type="checkbox"/> No longer operating 09 <input type="checkbox"/> Merged with (Control No.) _____ 10 <input type="checkbox"/> Duplicate (Control No. of duplicate) _____ 11 <input type="checkbox"/> Other noninterview – Specify _____</div> <div>2. Date of interview Month Day Year</div> <div>3. Field Representative name FR Code</div>																																										

Section D – ARRANGING THE ADMINISTRATOR APPOINTMENT

1. INTRODUCTION

Good morning (afternoon). My name is . . . I’m from the Bureau of the Census. We are currently conducting the National Home and Hospice Care Survey for the National Center for Health Statistics which is part of the Centers for Disease Control and Prevention. We are studying home health agencies, hospices and their patients. You should have received a letter from Mr. John Anderson, the Acting Director of the National Center for Health Statistics, which describes this project. Have you received this letter?

☐ Yes – Skip to Item 3 , NAME VERIFICATION.

☐ No – Continue with Item 2, SURVEY EXPLANATION.

2. SURVEY EXPLANATION

If administrator wants a copy of the letter, explain that you will bring a copy when you visit the agency.

I’m sorry that you did not receive the letter. Let me briefly outline its contents.

The National Home and Hospice Care Survey is authorized under Section 306 of the Public Health Service Act to collect information about home and hospice care agencies, their services, and patients. The survey is endorsed by the National Association for Home Care and the National Hospice Organization. The statistics compiled from the data are used to support research for effective treatment of long-term health problems and to study utilization of hospice and home care agencies and the efficient use of the Nation’s health care resources.

All information which would permit identification of the individual patient or agency will be held in strict confidence, will be used ONLY by persons involved in the survey and only for the purposes of the survey, and will not be disclosed or released to others for any purpose.

The survey includes a small sample of hospices and home health agencies. Although your participation is voluntary and there are no penalties for refusing to answer any questions, it is essential that we obtain data from all sample agencies.

READ IF NECESSARY:

We are asking participants for a list of current patients and a list of discharges during a designated one-month period. We will draw a sample of 6 current patients and a sample of 6 discharges from the lists and complete a questionnaire for each of the 12 sampled patients.

Continue with Item 3, NAME VERIFICATION.

3. NAME VERIFICATION

I would like to verify some information from my records. Is (Name of agency on label) the correct name of your agency?

☐ Yes – Go to Item 4, ADDRESS VERIFICATION

☐ No – Enter correct agency name below.↴

4. ADDRESS VERIFICATION

Is (Address of agency on label) the correct address?

☐ Yes – Go to Item 5 – SET APPOINTMENT

☐ No – Enter correct agency address below. ↴

NumberStreetP.O. Box, Route, etc.

City or town

StateZIP Code

5. SET APPOINTMENT

I would like to arrange a morning appointment at your convenience to conduct the survey. What would be a convenient date and time to visit your agency?

DayDateTimea.m.p.m.

DayDateTimea.m.p.m.

6. Could you give me directions to your agency from some easy to identify starting point? (Record directions in number 7 below.)

Thank you very much for your time. I will see you at (Time) on (Date). Good-bye.

7. DIRECTIONS TO AGENCY (If needed)

Section E – QUESTIONS ABOUT THE AGENCY

Before I begin the interview, I’d like to take a moment to explain the purpose of the survey. I believe you (received/did not receive) the letter from the National Center for Health Statistics.

If administrator did not receive the letter, hand him/her a copy. Allow him/her to briefly read it through.

As it says in the letter, the purpose of the National Home and Hospice Care Survey is to collect information about hospices and home health agencies such as yours. The information you provide is strictly confidential and will be used only by persons involved in the survey and only for the purposes of the survey.

HAND FLASHCARD 1

1a. What is the type of ownership of this agency as shown on this card?

Mark (X) only ONE box.

01 ☐ PROPRIETARY – Includes individual or private, partnership, corporation

02 ☐ NONPROFIT – Includes church-related, nonprofit corporation, other nonprofit ownership

03 ☐ STATE OR LOCAL GOVERNMENT – Includes State, county, city, city-county, hospital district or authority

04 ☐ FEDERAL GOVERNMENT – Includes USPHS, Armed Forces, Veterans Administration

05 ☐ Other – Specify ↴

b. Does this agency operate under the general authority of a hospital?

01 ☐ Yes

02 ☐ No

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Section E – QUESTIONS ABOUT THE AGENCY – Continued	
1c. Does this agency operate under the general authority of a nursing home?	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No
d. Is (Name of agency) a member of a group of agencies operating under one corporate authority or corporate ownership?	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No
2. Does this agency operate under the authority of a Health Maintenance Organization (HMO)?	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No
3a. Is this agency certified under Medicare as a Home Health Agency?	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No 03 <input type="checkbox"/> Certification pending
b. Is this agency certified under Medicare as a Hospice?	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No 03 <input type="checkbox"/> Certification pending
4a. Is this agency certified under Medicaid as a Home Health Agency?	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No 03 <input type="checkbox"/> Certification pending
b. Is this agency certified under Medicaid as a Hospice?	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No 03 <input type="checkbox"/> Certification pending
5a. Does this agency provide bereavement care to families of the patients that you serve?	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No
b. Does this agency provide pastoral care?	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No
HAND FLASHCARD 2 6. Does this agency provide any of the following services? Mark (X) all that apply. Probe: Any other services?	00 <input type="checkbox"/> None 01 <input type="checkbox"/> Continuous home care 02 <input type="checkbox"/> Counseling 03 <input type="checkbox"/> Dental treatment services 04 <input type="checkbox"/> Dietary and nutritional services 05 <input type="checkbox"/> Durable medical equipment and supplies 06 <input type="checkbox"/> Enterostomal therapy 07 <input type="checkbox"/> High tech care (e.g., IV therapy) 08 <input type="checkbox"/> Homemaker/Companion services 09 <input type="checkbox"/> Meals on Wheels 10 <input type="checkbox"/> Medications 11 <input type="checkbox"/> Occupational therapy/Vocational therapy 12 <input type="checkbox"/> Oral hygiene/Prevention services 13 <input type="checkbox"/> Personal care 14 <input type="checkbox"/> Physical therapy 15 <input type="checkbox"/> Physician services 16 <input type="checkbox"/> Referral services 17 <input type="checkbox"/> Respite care (inpatient) 18 <input type="checkbox"/> Skilled nursing services 19 <input type="checkbox"/> Social Services 20 <input type="checkbox"/> Speech therapy/Audiology 21 <input type="checkbox"/> Spiritual care 22 <input type="checkbox"/> Transportation 23 <input type="checkbox"/> Volunteers 24 <input type="checkbox"/> Other services – Specify <input checked="" type="checkbox"/> _____ _____
7a. Does this agency currently have any active patients?	01 <input type="checkbox"/> Yes – GO to item 7b 02 <input type="checkbox"/> No – THANK THE RESPONDENT, END THE INTERVIEW, AND MARK CODE 11 IN SECTION C ON THE COVER PAGE.
b. What is the number of your current active patients?	_____ Number of patients 99999 <input type="checkbox"/> Don't know
8a. What is the number of home health care patients currently being served by this agency?	_____ Number of home health patients 0000 <input type="checkbox"/> None 99999 <input type="checkbox"/> Don't know
b. What is the number of hospice care patients currently being served by this agency?	_____ Number of hospice patients 0000 <input type="checkbox"/> None 99999 <input type="checkbox"/> Don't know

Section E – QUESTIONS ABOUT THE AGENCY – Continued

READ

To complete this survey, I will need a list of all current home health and hospice patients, and a list of all home health and hospice discharges for the month of (Insert discharge sample month and year).

From these lists, I will draw a sample of up to 6 current patients and up to 6 discharges.

9a. From whom shall I obtain the list of current patients?

Name

Title

I will need these patients' medical records and the cooperation of a staff member best acquainted with these patients in order to obtain the information on this questionnaire.

Hand the administrator a copy of the current patient questionnaire. Allow him/her to examine it briefly. Retrieve the questionnaire and continue reading.

I will not be contacting or interviewing the patients in any way. I will depend on your staff to consult the medical records.

b. Would (person named in item 9a) know which staff member I should interview for those patients selected for the sample?

- 01 ☐ Yes – GO to item 10a
02 ☐ No – Determine which staff member would have this knowledge and enter the name and title below. ↴

Name

Title

10a. From whom shall I obtain the list of discharges?

☐ Same as 9a

Name

Title

I will need the help of a staff person familiar with the discharge records to aid me in completing the information requested in this questionnaire.

Hand the administrator a copy of the discharged patient questionnaire. Allow him/her to examine it briefly. Retrieve the questionnaire and continue reading.

b. Would (person named in item 10a) know which staff member I should interview for those discharges that fall into the sample?

- 01 ☐ Yes – GO to item 11 below
02 ☐ No – Determine which staff member would have this knowledge and enter the name and title below. ↴

Name

Title

11. Thank you for your time. I will be checking with you before I leave to say good-bye.

At this time, could you introduce me to (Names of person(s) listed in items 9a, 9b, 10a, and 10b).

Notes